| IPDR6702 |                                |              |           | NORTH CAROLINA  |                | PAG              | E: 1                |                |
|----------|--------------------------------|--------------|-----------|---|----------------|------------------|---------------------|----------------|
|          | 02/08/2004                     |              |           | CHECKWRITE SUMMARY REPORT                                       |                |                  |                     |                |
|          |                                |              | CF        | MECKWRITE DATE: 02/10/2004 FINANCIAL PAYER: NCDMH               |                |                  |                     |                |
|          |                                |              |           | LIMINGALIA LILLAN, MODUL  |                |                  |                     |                |
| PROVIDER |                                | HIGH DENIAL  | NUMBER OF |   | myo            | momar            | TOTAL               | TOTAL          |
| NUMBER   | PROVIDER NAME                  | EOBS         | DENIALS   | DESCRIPTION   | TNC<br>DENIALS | TOTAL<br>DENIALS | CLAIMS<br>FINALIZED | CLAIMS<br>PAID |
| 2404901  |                                | 21           | 0.4.0     | DUDITONTE OF CLAIM-CVCTPM                                       |                |                  |                     |                |
| 3404901  | SMOKY MOUNTAINM<br>H/DD/SAS    | 21           | 848       | DUPLICATE OF CLAIM-SYSTEM                                       |                |                  |                     |                |
|          |                                |              |           |   |                |                  |                     |                |
|          |                                | 11           | 241       | CLIENT NOT ELIGIBLE ON SERVICE                                  |                | 1089             | 1129                | 40             |
|          |                                |              |           | DATE  | 0              | 1003             | 1129                | 40             |
|          |                                |              |           |   |                |                  |                     |                |
| 3404902  | BLUE RIDGE COMM                | 8599         | 610       | DETAIL NOT COVERED BY COMBINAT                                  |                |                  |                     |                |
|          | UNITY                          |              |           | ION OF RECIPIENT, PROVIDER AND                                  |                |                  |                     |                |
|          |                                |              |           | BENEFIT PACKAGE.  |                |                  |                     |                |
|          |                                | 191          | 77        | CLIENT ID NUMBER DOES NOT MATC                                  | 1              | 767              | 2611                | 1844           |
|          |                                |              |           | H PATIENT NAME  |                |                  |                     |                |
|          |                                |              |           |   |                |                  |                     |                |
|          |                                | 21           | 75        | DUPLICATE OF CLAIM-SYSTEM                                       |                |                  |                     |                |
|          |                                |              |           |   |                |                  |                     |                |
| 2404004  |                                | 0            | 0         | *** NO DATE TO DEPOSE ***                                       |                |                  |                     |                |
| 3404904  | WESTERN HIGHLAN<br>DS LME      | U            | U         | *** NO DATA TO REPORT ***                                       |                |                  |                     |                |
|          | 4044                           |              |           |   |                |                  |                     |                |
|          |                                | 0            | 0         |   |                |                  |                     |                |
|          |                                | 1            |           |   | 0              | 0                | 0                   | 0              |
| 2404005  |                                | 0            | 0         | LILL MO DAMA TO DEPORT ALL                                      |                |                  |                     |                |
| 3404905  | TREND COMM MENT<br>AL HLTH CTR | 0            | v         | *** NO DATA TO REPORT ***                                       |                |                  |                     |                |
|          |                                |              |           |   |                |                  |                     |                |
|          |                                | 0            | 0         |   |                | 0                | 0                   | 0              |
|          |                                | -            | -         |   | 0              | 0                | 0                   | 0              |
| 3404907  |                                | 8599         | 58        | DETAIL NOT COVERED BY COMBINAT                                  |                |                  |                     |                |
| 3404307  | RUTHERFORD-POLK                | 0000         | 50        | ION OF RECIPIENT, PROVIDER AND                                  |                |                  |                     |                |
|          |                                |              |           | BENEFIT PACKAGE.  |                |                  |                     |                |
|          |                                | 8622         | 40        | 60 RESIDENTIAL LEVEL II TREATM                                  | 26             | 191              | 1120                | 929            |
|          |                                |              |           | ENT RECEIVED, PA IS REQUIRED                                    | 2.0            | 131              | 1120                | 323            |
|          |                                |              |           | FOR ADDITIONAL SERVICE.   |                |                  |                     |                |
|          |                                | 10           | 31        | DIAGNOSIS OR SERVICE INVALID F                                  |                |                  |                     |                |
|          |                                |              |           | OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR        |                |                  |                     |                |
|          |                                |              |           | DIAGNOSIS, FROCEBORE CODE FOR                                   |                |                  |                     |                |
| 3404910  | PATHWAYS                       | 8505         | 119       | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET                        |                |                  |                     |                |
|          |                                |              |           | NT BUDGET   |                |                  |                     |                |
|          |                                |              |           |   |                |                  |                     |                |
|          |                                | 24           | 119       | PROCEDURE CODE, PROCEDURE/MODI<br>FIER COMBINATION OR PROCEDURE | 1              | 491              | 835                 | 344            |
|          |                                |              |           | CODE/TYPE OF SERVICE COMBINATI                                  |                |                  |                     |                |
|          |                                | 21           | 89        | DUPLICATE OF CLAIM-SYSTEM                                       |                |                  |                     |                |
|          |                                |              |           |   |                |                  |                     |                |
|          |                                |              |           |   |                |                  |                     |                |
| 3404912  | CATAWBA COUNTYM                | 11           | 6         | CLIENT NOT ELIGIBLE ON SERVICE                                  |                |                  |                     |                |
|          | ENTAL HEALT                    |              |           | DATE  |                |                  |                     |                |
|          |                                | <del> </del> |           |   |                |                  |                     |                |
|          |                                | 0            | 0         |   | 0              | 6                | 21                  | 15             |
|          | -                              | 1            |           |   |                |                  |                     |                |
| 3404913  | MECKLENBURG COM                | 8505         | 151       | CLAIM DENIED DUE TO INSUFFICIE                                  |                |                  |                     |                |
|          | ENTAL HEALT                    | 1            |           | NT BUDGET   |                |                  |                     |                |
|          |                                |              |           |   |                |                  |                     |                |
|          |                                | 8933         | 24        | ADTNC INELIGIBLE TO RECEIVE SE<br>RVICES IN IPRS.               | 32             | 210              | 1400                | 1190           |
|          |                                |              |           |   |                |                  |                     |                |
|          |                                | 8599         | 20        | DETAIL NOT COVERED BY COMBINAT                                  |                |                  |                     |                |
|          |                                |              |           | ION OF RECIPIENT, PROVIDER AND                                  |                |                  |                     |                |
|          |                                |              |           | BENEFIT PACKAGE.  |                |                  |                     |                |
| 3404916  | CROSSROADS BEHA                | 8621         | 16        | 60 RESIDENTIAL LEVEL III TREAT                                  |                |                  |                     |                |
|          | VIORAL HEAL                    |              |           | MENT RECEIVED, PA IS REQUIRED                                   |                |                  |                     |                |
|          | <u> </u>                       | 1            |           | FOR ADDITIONAL SERVICE.   |                |                  |                     |                |
|          |                                | 8599         | 14        | DETAIL NOT COVERED BY COMBINAT                                  | 2              | 37               | 636                 | 599            |
|          |                                |              |           | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.                 |                |                  |                     |                |
|          |                                |              |           |   |                |                  |                     |                |
|          |                                | 21           | 5         | DUPLICATE OF CLAIM-SYSTEM                                       |                |                  |                     |                |
|          | -                              | +            |           |   |                |                  |                     |                |
|          | •                              |              |           |   |                |                  |                     |                |

|          |                       | T  | 1         | T   |         |         | TOTAL     | TOTAL    |
|----------|-----------------------|--|-----------|---|---------|---------|-----------|----------|
| PROVIDER |                       | HIGH DENIAL                                      | NUMBER OF | DESCRIPTION   | TNC     | TOTAL   | CLAIMS    | CLAIMS   |
| NUMBER   | PROVIDER NAME         | EOBS   | DENIALS   | DESCRIPTION   | DENIALS | DENIALS | FINALIZED | PAID     |
| 3404917  | CENTERPOINT HUM       | 8599   | 3176      | DETAIL NOT COVERED BY COMBINAT                                |         |         |           |          |
|          | AN SERVICES           |  |           | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.               |         |         |           | <b> </b> |
|          |                       |  |           |   |         |         |           |          |
|          |                       | 8326   | 1209      | ATTENDING PROVIDER NUMBER IS R EQUIRED WHEN BILLED WITH GROUP | 1       | 4448    | 4574      | 126      |
|          |                       |  |           | NUMBER. ADD ATTENDING NUMBER A                                |         |         |           |          |
|          |                       | 142  | 0.5       | CLITIVE ID WINDER NOT ON CENTER                               |         |         |           |          |
|          |                       | 143  | 25        | CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE                |         |         |           | <b></b>  |
|          |                       |  |           |   |         |         |           |          |
| 3404918  | ROCKINGHAM CO M       | 8599   | 76        | DETAIL NOT COVERED BY COMBINAT                                |         |         |           | <b> </b> |
|          | ENTAL HEALT           |  |           | ION OF RECIPIENT, PROVIDER AND                                |         |         |           |          |
|          |                       |  |           | BENEFIT PACKAGE.  |         |         |           | <b>—</b> |
|          |                       | 11   | 56        | CLIENT NOT ELIGIBLE ON SERVICE                                | 11      | 202     | 1841      | 1639     |
|          |                       |  |           | DATE  |         |         |           |          |
|          |                       |  |           |   |         |         |           |          |
|          |                       | 21   | 20        | DUPLICATE OF CLAIM-SYSTEM                                     |         |         |           |          |
|          |                       |  |           |   |         |         |           | <b> </b> |
|          |                       |  |           |   |         |         |           |          |
| 3404919  | GUILFORD CO MEN       | 8505   | 1062      | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET                      |         |         |           | <b>—</b> |
|          | TAL HEALTHC           | <u> </u>   |           |   |         |         |           |          |
|          |                       | 11   | 320       | CLIENT NOT ELIGIBLE ON SERVICE                                |         |         |           |          |
|          |                       |  |           | DATE  | 262     | 2426    | 3678      | 1252     |
|          |                       |  |           |   |         |         |           |          |
|          |                       | 8599   | 239       | DETAIL NOT COVERED BY COMBINAT                                |         |         |           |          |
|          |                       |  |           | ION OF RECIPIENT, PROVIDER AND                                |         |         |           |          |
|          |                       | +  |           | BENEFIT PACKAGE.  |         |         |           | $\vdash$ |
| 3404920  | ALAMANCE CASWEL       | 0  | 0         | *** NO DATA TO REPORT ***                                     |         |         |           |          |
|          | L AREA MH D           |  |           |   |         |         |           |          |
|          |                       |  |           |   |         |         |           |          |
|          |                       | 0  | 0         |   | 0       | 0       | 0         | 0        |
|          |                       |  |           |   |         |         |           | <b> </b> |
| 3404921  | ORANGE PERSON C       | 5312   | 648       | PRIOR AUTHORIZED DOLLARS EXCEE                                |         |         |           |          |
|          | HATHAM AREA           |  |           | DED   |         |         |           |          |
|          |                       |  |           |   |         |         |           |          |
|          |                       | 5404   | 250       | SEVERE DUPLICATE: SAME ATTD PR                                | 26      | 1514    | 4640      | 3126     |
|          |                       |  |           | OV/PCODE/TOS/DOS/MOD  |         |         |           |          |
|          |                       |  |           |   |         |         |           |          |
|          |                       | 8599   | 172       | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND |         |         |           | <b> </b> |
|          |                       |  |           | BENEFIT PACKAGE.  |         |         |           |          |
| 3404922  | mun pupuny canus      | 21   | 3110      | DUPLICATE OF CLAIM-SYSTEM                                     |         |         |           | <b>—</b> |
| 3404322  | THE DURHAM CENT<br>ER | 2.2  | 5110      | both of call of order   |         |         |           |          |
|          |                       |  |           |   |         |         |           |          |
|          |                       | 191  | 310       | CLIENT ID NUMBER DOES NOT MATC                                | 0       | 4081    | 6784      | 2703     |
|          |                       |  |           | H PATIENT NAME  |         |         |           |          |
|          |                       |  |           |   |         |         |           |          |
|          |                       | 8599   | 270       | DETAIL NOT COVERED BY COMBINAT                                |         |         |           |          |
|          | <u> </u>              | <del></del>                                      | <u> </u>  | ION OF RECIPIENT, PROVIDER AND<br>BENEFIT PACKAGE.            |         |         |           |          |
|          |                       |  |           |   |         |         |           |          |
| 3404923  | VGFW AREA AUTHO       | 8505   | 181       | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET                      |         |         |           | <b>—</b> |
|          | RITY                  |  | 1         |   |         |         |           |          |
|          |                       | 8599   | 62        | DETAIL NOT COVERED BY COMBINAT                                |         |         |           |          |
|          |                       | 0.33   |           | ION OF RECIPIENT, PROVIDER AND                                | 6       | 380     | 1044      | 664      |
|          |                       |  |           | BENEFIT PACKAGE.  |         |         |           |          |
|          |                       | 21   | 53        | DUPLICATE OF CLAIM-SYSTEM                                     |         |         |           |          |
|          |                       |  |           |   |         |         |           |          |
|          |                       | <del>                                     </del> |           |   |         |         |           | <b>—</b> |
| 3404924  | PIEDMONT AREA M       | 8525   | 145       | CLAIM DENIED, REFERRING PROVID                                |         |         |           |          |
|          | H/DD/SAS              | <u> </u>   |           | ER MUST BE AN LMA.  |         |         |           |          |
|          |                       | +  |           |   |         |         |           |          |
|          |                       | 191  | 4         | CLIENT ID NUMBER DOES NOT MATC                                | 0       | 149     | 149       | 0        |
|          |                       |  |           | H PATIENT NAME  |         |         |           |          |
|          |                       |  |           |   |         |         |           |          |
| 3404925  | SANDHILLS CENTE       | 8505   | 489       | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET                      |         |         |           | <b> </b> |
| -        | R FOR MH/DD           | +  | -         | W1 202021   |         |         |           |          |
|          |                       | 2500   |           |   |         |         |           |          |
|          |                       | 8502   | 28        | CLAIM DENIED DUE TO INSUFFICIE  NT ALLOTMENT                  | 14      | 560     | 717       | 157      |
|          |                       | <u> </u>   |           |   |         |         |           |          |
|          |                       |  |           | 1   | . —     | 1       | , — —     | . —      |
|          |                       | 8599   | 21        | DETAIL NOT COVERED BY COMBINAT                                |         |         | ļI        | L        |
|          |                       | 8599   | 21        | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND |         |         |           |          |
|          |                       | 8599   | 21        |   |         |         |           |          |

|                    |                                |             |           |                                |         |         | TOTAL     | TOTAL  |
|--------------------|--------------------------------|-------------|-----------|--------------------------------|---------|---------|-----------|--------|
| PROVIDER<br>NUMBER |                                | HIGH DENIAL | NUMBER OF | DESCRIPTION                    | TNC     | TOTAL   | CLAIMS    | CLAIMS |
| NUMBER             | PROVIDER NAME                  | EOBS        | DENIALS   | DESCRIPTION                    | DENIALS | DENIALS | FINALIZED | PAID   |
| 3404926            | SOUTHEASTERN RE                | 8505        | 754       | CLAIM DENIED DUE TO INSUFFICIE |         |         |           |        |
|                    | G MENTAL HL                    |             |           | NT BUDGET                      |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                | 11          | 170       | CLIENT NOT ELIGIBLE ON SERVICE | 114     | 1362    | 3316      | 1954   |
|                    |                                |             |           | DATE                           |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                | 8599        | 137       | DETAIL NOT COVERED BY COMBINAT |         |         |           |        |
|                    |                                |             |           | ION OF RECIPIENT, PROVIDER AND |         |         |           |        |
|                    |                                |             |           | BENEFIT PACKAGE.               |         |         |           |        |
| 3404927            |                                | 2020        | 1050      | CLAIM DENIED DUE TO INSUFFICIE |         |         |           |        |
| 3404927            | CUMBERLAND CO M                | 8505        | 1050      | NT BUDGET                      |         |         |           |        |
|                    | HC                             |             |           | N1 202021                      |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                | 8599        | 260       | DETAIL NOT COVERED BY COMBINAT | 23      | 1531    | 5211      | 3680   |
|                    |                                |             |           | ION OF RECIPIENT, PROVIDER AND |         |         |           |        |
|                    |                                |             |           | BENEFIT PACKAGE.               |         |         |           |        |
|                    |                                | 8800        | 93        | FURTHER PROCESSING NECESSARY,  |         |         |           |        |
|                    |                                | 0000        | 33        | PLEASE CHECK FOR CLAIM ON      |         |         |           |        |
|                    |                                |             |           | FUTURE RA'S.                   |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
| 3404929            | LEE HARNETT MH/                | 8599        | 47        | DETAIL NOT COVERED BY COMBINAT |         |         |           |        |
|                    | DD/SAS                         |             |           | ION OF RECIPIENT, PROVIDER AND |         |         |           |        |
|                    |                                |             |           | BENEFIT PACKAGE.               |         |         |           |        |
|                    |                                | 11          | 31        | CLIENT NOT ELIGIBLE ON SERVICE |         | 4       | 0.000     | 051-   |
|                    | 1                              | F-          |           | DATE                           | 1       | 149     | 3666      | 3517   |
|                    |                                | 1           |           | <u> </u>                       |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                | 120         | 27        | CLIENT ID NUMBER MISSING OR IN |         |         |           |        |
|                    |                                |             |           | VALID. ENTER CID AND SUBMIT    |         |         |           |        |
|                    |                                |             |           | AS A NEW CLAIM                 |         |         |           |        |
| 3404930            |                                | 21          | 4         | DUPLICATE OF CLAIM-SYSTEM      |         |         |           |        |
| 2404320            | JOHNSTON COUNTY<br>MNTL HLTHC  | 21          | 4         | DOFBICATE OF CHAIM-SISIEM      |         |         |           |        |
|                    | MNIL HLINC                     |             |           |                                |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                | 8931        | 2         | AMTNC INELIGIBLE TO RECEIVE SE | 2       | 6       | 114       | 108    |
|                    |                                |             |           | RVICES IN IPRS.                |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
| 3404931            |                                | 21          | 98        | DUPLICATE OF CLAIM-SYSTEM      |         |         |           |        |
| 2404331            | WAKE CO HUM SVC                | 21          | 30        | DOFBICATE OF CHAIM-SISIEM      |         |         |           |        |
|                    | BILLING OF                     |             |           |                                |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                | 0           | 0         |                                | 0       | 98      | 147       | 49     |
|                    |                                |             |           |                                |         |         |           |        |
| 3404932            |                                | 5404        | 0         | SEVERE DUPLICATE: SAME ATTD PR |         |         |           |        |
| 3404932            | RANDOLPH/SANDHI<br>LLS CO MH C | 3404        | -         | OV/PCODE/TOS/DOS/MOD           |         |         |           |        |
|                    | LLS CO MR C                    |             |           |                                |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                | 8505        | 1         | CLAIM DENIED DUE TO INSUFFICIE | 2       | 6       | 53        | 47     |
|                    |                                |             |           | NT BUDGET                      |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                | 8932        | 1         | CMTNC INELIGIBLE TO RECEIVE SE |         |         |           |        |
|                    |                                | <u> </u>    |           | RVICES IN IPRS.                |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
| 3404933            | SOUTHEASTERN CT                | 8505        | 1170      | CLAIM DENIED DUE TO INSUFFICIE |         |         |           |        |
|                    | R FOR MH/DD                    | 1           |           | NT BUDGET                      |         |         |           |        |
|                    |                                | 1           |           |                                |         |         |           |        |
|                    |                                | 8800        | 125       | FURTHER PROCESSING NECESSARY,  | 46      | 1434    | 2360      | 926    |
|                    |                                |             |           | PLEASE CHECK FOR CLAIM ON      | 40      | 1434    | 2360      | 320    |
|                    |                                |             |           | FUTURE RA'S.                   |         |         |           |        |
|                    |                                | 2024        |           |                                |         |         |           |        |
|                    |                                | 8931        | 29        | AMTNC INELIGIBLE TO RECEIVE SE |         |         |           |        |
|                    |                                | -           |           | RVICES IN IPRS.                |         |         |           |        |
|                    |                                | 1           |           |                                |         |         |           |        |
| 3404934            | ONSLOW COUNTY B                | 537         | 90        | PROCEDURE IS NOT COVERED FOR T |         |         |           |        |
|                    | EHAVIORAL H                    | <u></u>     |           | HIS DATE OF SERVICE            |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                | 0505        | 0.4       | CLAIM DENTED DUE TO AVG        |         |         |           |        |
|                    |                                | 8505        | 84        | CLAIM DENIED DUE TO INSUFFICIE | 8       | 393     | 1158      | 765    |
|                    |                                | -           |           | NT BUDGET                      |         |         |           |        |
|                    |                                | 1           |           |                                |         |         |           |        |
|                    |                                | 11          | 56        | CLIENT NOT ELIGIBLE ON SERVICE |         |         |           |        |
|                    |                                |             |           | DATE                           |         |         |           |        |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                |             |           |                                | _       | -       | _         |        |
| 3404935            | WAYNE CO MENTAL                | 0           | U         | *** NO DATA TO REPORT ***      |         |         |           |        |
|                    | HEALTH CTR                     | 1           | 1         |                                |         |         |           |        |
|                    |                                | -           |           |                                |         |         |           |        |
|                    |                                | 0           | 0         |                                | 0       | 0       | 0         | 0      |
|                    |                                |             |           |                                |         |         |           | -      |
|                    |                                |             |           |                                |         |         |           |        |
|                    |                                |             |           | -                              |         |         |           |        |

|  |           |                 |              |           | T T T T T T T T T T T T T T T T T T T |     |        |       |  |
|--|-----------|-----------------|--------------|-----------|---------------------------------------|-----|--------|-------|--|
| Column   C   | PROVIDER  |                 | HIGH DENIAL  | NUMBER OF |                                       | TNC | TOTAL. |       |  |
| March   California   | NUMBER    | PROVIDER NAME   | EOBS         | DENIALS   | DESCRIPTION                           |     |        |       |  |
|  |           |                 |              |           |                                       |     |        |       |  |
| 100    | 3404936   | WILSON-GREENE M | 8931         | 13        |                                       |     |        |       |  |
|  |           | ENTAL HEALT     |              |           | RVICES IN IPRS.                       |     |        |       | <b> </b>   |
|  |           |                 |              |           |                                       |     |        |       | <del></del>                                      |
|  |           |                 | 8932         | 8         | CMTNC INELIGIBLE TO RECEIVE SE        | 20  | 40     | 470   | 400  |
| 1985      |           |                 |              | -         |                                       | 28  | 42     | 4 / U | 428  |
| 1979   1971      |           |                 |              |           |                                       |     |        |       |  |
| 1969   1   |           |                 |              |           |                                       |     |        |       |  |
| 1  |           |                 | 8935         | 7         |                                       |     |        |       |  |
| NEL SATING CO.    10   10   10   10   10   10   10   1   |           |                 |              |           | RVICES IN IPRS.                       |     |        |       |  |
| NEL SATING CO.    10   10   10   10   10   10   10   1   |           |                 |              |           |                                       |     |        |       |  |
| NEL SATING CO.    10   10   10   10   10   10   10   1   | 0.10.1000 |                 | 0.4          |           |                                       |     |        |       |  |
| 100    | 3404937   |                 | 21           | 24        | DUPLICATE OF CLAIM-SISTEM             |     |        |       | <b></b>  |
| 1975      |           | MNTL HLTH C     |              |           |                                       |     |        |       | <b>-</b>   |
| 1975      |           |                 |              |           |                                       |     |        |       |  |
| 131   131   1  |           |                 | 8505         | 15        | CLAIM DENIED DUE TO INSUFFICIE        | 1   | 42     | 656   | 614  |
|  |           |                 |              |           | NT BUDGET                             |     |        |       | ,,,,   |
|  |           |                 |              |           |                                       |     |        |       |  |
|  |           |                 |              |           |                                       |     |        |       |  |
|  |           |                 | 8931         | 1         |                                       |     |        |       |  |
| DETAIL REALT   |           |                 |              |           | RVICES IN IPRS.                       |     |        |       |  |
| DETAIL REALT   |           |                 |              |           |                                       |     |        |       |  |
| DETAIL REALT   | 2404020   |                 |              | 0         | ALL NO DIES TO DEPORT AND             |     |        |       | <b> </b>   |
| 1999   1998      | 7404328   |                 | U .          | o .       | NO DATA TO REPORT ***                 |     |        |       | <b> </b>   |
| MISSE MENTAL HE   24   332   PROCEDURE COSE, PROCEDURE MODIES  |           | ENTAL HEALT     |              |           |                                       |     |        |       | <b> </b>   |
| MISSE MENTAL HE   24   332   PROCEDURE COSE, PROCEDURE MODIES  |           | 1               | <del> </del> |           |                                       |     |        |       |  |
| MISSE MENTAL HE   24   332   PROCEDURE COSE, PROCEDURE MODIES  |           |                 | 0            | 0         |                                       | 0   | 0      | 0     | 0  |
| PIECONSTRUCTION OF PROCESSES   |           |                 | 1            |           |                                       | 0   |        |       | -  |
| PIECONSTRUCTION OF PROCESSES   |           |                 |              |           |                                       |     |        |       |  |
| ALTE CENTER    1959   137   DETAIL NOT COVERED BY COMMINT   1959   137   DETAIL NOT COVERED BY COMMINT   1959   138   13 | 3404939   | NEUSE MENTAL HE | 24           | 332       | PROCEDURE CODE, PROCEDURE/MODI        |     |        |       |  |
| 100    |           |                 |              |           |                                       |     |        |       |  |
|  |           |                 |              |           | CODE/TYPE OF SERVICE COMBINATI        |     |        |       |  |
|  |           |                 |              |           |                                       |     |        |       |  |
| SECTION   SECT   |           |                 | 8599         | 137       |                                       | 28  | 1051   | 2729  | 1678   |
| S18   15   |           |                 |              |           |                                       |     |        |       |  |
|  |           |                 |              |           | BENEFII FACAGE.                       |     |        |       | $\vdash$   |
|  |           |                 | 8518         | 135       | CLAIM DENIED, SUBMITTED BEYOND        |     |        |       | <b></b>  |
| 3004941   27T CO MUNICOS   120   |           |                 |              |           |                                       |     |        |       |  |
| SAMPANI  |           |                 |              |           |                                       |     |        |       |  |
| AS CENTER    NAID. ENTRE CID AND SUBMIT   NAI |           |                 |              |           |                                       |     |        |       |  |
| AS CENTER   MAILOL ENTER CLOAMS SUBMIT   MAIL | 3404941   | PITT CO MH/DD/S | 120          | 243       | CLIENT ID NUMBER MISSING OR IN        |     |        |       |  |
|  |           |                 |              |           |                                       |     |        |       |  |
|  |           |                 |              |           | AS A NEW CLAIM                        |     |        |       |  |
|  |           |                 |              |           |                                       |     |        |       |  |
|  |           |                 | 191          | 52        |                                       | 21  | 471    | 2060  | 1589   |
|  |           |                 |              |           | n PATIENT NAME                        |     |        |       | -  |
|  |           |                 |              |           |                                       |     |        |       | <b>—</b>   |
|  |           |                 | 8599         | 4.4       | DETAIL NOT COVERED BY COMBINAT        |     |        |       | <b>—</b>   |
| SAMPLE CHOMANN   |           |                 |              |           |                                       |     |        |       |  |
| UMAN SERVIC  |           |                 |              |           |                                       |     |        |       |  |
| UMAN SERVIC  |           |                 |              |           |                                       |     |        |       |  |
| MAN SERVIC   | 3404942   | ROANOKE CHOWANH | 0            | 0         | *** NO DATA TO REPORT ***             |     |        |       |  |
|  |           |                 |              |           |                                       |     |        |       |  |
| 3404943 ALBEMARIE MENTA 21 2010 BUFLICATE OF CLAIM-SYSTEM  |           |                 |              |           |                                       |     |        |       |  |
| 3404943 ALBEMARIE MENTA 21 2010 BUFLICATE OF CLAIM-SYSTEM  |           |                 |              |           |                                       |     |        |       |  |
| LEALTH CE  |           |                 | U            | U         |                                       | 0   | 0      | 0     | 0  |
| LEALTH CE  |           |                 | 1            |           |                                       |     |        |       | <b> </b>   |
| LEALTH CE  | 3404943   | 31 DEMART D. M  | 21           | 2010      | DUPLICATE OF CLAIM-SYSTEM             |     |        |       | <del>                                     </del> |
| 11   |           |                 | <del> </del> |           |                                       |     |        |       |  |
| DATE  BATE   |           |                 | <del> </del> |           | <u> </u>                              |     |        |       |  |
| DATE  BATE   |           |                 | 1            |           |                                       |     |        |       |  |
| DATE   |           |                 | 11           | 74        |                                       | 52  | 2241   | 2720  | 479  |
| SAME ASSTROLLE HUMA 21 200 DOPLICATE OF CLAIM-SYSTEM 3404944 EASTFOLINE HUMA 3404944 |           |                 |              |           | DATE                                  |     |        |       |  |
| SAME ASSTROLLER AND SERVICES AND SERVICES AND SERVICES AND SERVICES SERVICE |           |                 |              |           |                                       |     |        |       |  |
| SAME ASSTROLLER AND SERVICES AND SERVICES AND SERVICES AND SERVICES SERVICE |           |                 | 0500         |           |                                       |     |        |       |  |
| BENEFIT PACKAGE.   |           |                 | 8599         | 41        |                                       |     |        |       | <b>  </b>  |
| 3404944 EASTPOINTE HUMA 21 200 BUFLICATE OF CLAIM-SYSTEM   |           |                 | 1            |           |                                       |     |        |       | <b> </b>   |
| N SERVICES  8935  4 ASTNC INELIGIBLE TO RECEIVE SE  RVICES IN IPRS.  164  523  3361  28  77  DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND  |           |                 |              |           | PROPERTY FROM SEC.                    |     |        |       | <del>                                     </del> |
| N SERVICES  8935 84 ASTRC INELIGIBLE TO RECEIVE SE 164 523 3361 28 RVICES IN IPRS.  5599 77 DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND  | 3404944   | PACEDOTNEE WWW  | 21           | 200       | DUPLICATE OF CLAIM-SYSTEM             |     |        |       |  |
| 8935 84 ASTNC INELIGIBLE TO RECEIVE SE 164 523 3361 28  RVICES IN IPRS. 164 523 3361 28  | 3404944   |                 | <del> </del> |           |                                       |     |        |       |  |
| RVICES IN IPRS.  RVICES IN IPRS. RVICES IN IPRS. RVICES IN IPRS.  |           | N DERVICES      | <del> </del> |           | <u> </u>                              |     |        |       |  |
| RVICES IN IPRS.  RVICES IN IPRS. RVICES IN IPRS. RVICES IN IPRS.  |           |                 | 1            |           |                                       |     |        |       |  |
| NVICES IN IPRS. STATE OF THE PROPERTY OF THE P |           |                 | 8935         | 84        |                                       | 164 | 523    | 3361  | 2838   |
| ION OF RECIPIENT, PROVIDER AND   |           |                 |              |           | RVICES IN IPRS.                       |     |        |       |  |
| ION OF RECIPIENT, PROVIDER AND   |           |                 |              |           |                                       |     |        |       |  |
| ION OF RECIPIENT, PROVIDER AND   |           |                 |              |           |                                       |     |        |       |  |
|  |           |                 | 8599         | 77        |                                       |     |        |       |  |
| BEARS 11 FALANDE.  |           |                 |              |           |                                       |     |        |       | <b>—</b>   |
|  |           |                 |              |           | PROPERTY FROM SEC.                    |     |        |       | <del>                                     </del> |
|  |           |                 |              |           |                                       |     |        |       | $\vdash$   |

|          |                 |             |           |                                |         |         | TOTAL     | TOTAL  |
|----------|-----------------|-------------|-----------|--------------------------------|---------|---------|-----------|--------|
| PROVIDER |                 | HIGH DENIAL | NUMBER OF |                                | TNC     | TOTAL   | CLAIMS    | CLAIMS |
| NUMBER   | PROVIDER NAME   | EOBS        | DENIALS   | DESCRIPTION                    | DENIALS | DENIALS | FINALIZED | PAID   |
|          |                 |             |           |                                |         |         |           |        |
| 3404946  | FOOTHILLS AREAM | 143         | 47        | CLIENT ID NUMBER NOT ON STATE  |         |         |           |        |
|          | ENTAL HEALT     |             |           | ELIGIBILITY FILE               |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 | 191         | 31        | CLIENT ID NUMBER DOES NOT MATC |         | 8 127   | 1149      | 1022   |
|          |                 |             |           | H PATIENT NAME                 |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 | 8599        | 31        | DETAIL NOT COVERED BY COMBINAT |         |         |           |        |
|          |                 |             |           | ION OF RECIPIENT, PROVIDER AND |         |         |           |        |
|          |                 |             |           | BENEFIT PACKAGE.               |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
| 3404957  | TIDELAND MENTAL | 8505        | 2409      | CLAIM DENIED DUE TO INSUFFICIE |         |         |           |        |
|          | HEALTH CTR      |             |           | NT BUDGET                      |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 | 8800        | 54        | FURTHER PROCESSING NECESSARY,  |         | 0 2463  | 2465      |        |
|          |                 |             |           | PLEASE CHECK FOR CLAIM ON      |         |         |           |        |
|          |                 |             |           | FUTURE RA'S.                   |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
| 3404959  | DAVIDSON CO MEN | 0           | 0         | *** NO DATA TO REPORT ***      |         |         |           |        |
|          | TAL HLTH CT     |             |           |                                |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 | 0           | 0         |                                |         | 0 0     | C         | ) (    |
|          |                 |             |           |                                |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
| 3404979  | NEW RIVER AREAM | 8505        | 59        | CLAIM DENIED DUE TO INSUFFICIE |         |         |           |        |
|          | H/DD/SA PRO     |             |           | NT BUDGET                      |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 | 8800        | 11        | FURTHER PROCESSING NECESSARY,  |         | 0 72    | 91        | 19     |
|          |                 |             |           | PLEASE CHECK FOR CLAIM ON      |         |         |           |        |
|          |                 |             |           | FUTURE RA'S.                   |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 | 191         | 2         | CLIENT ID NUMBER DOES NOT MATC |         |         |           |        |
|          |                 |             |           | H PATIENT NAME                 |         |         |           |        |